Editorials

Open Section - open minds

When King William IV, responding to the petition of the Physicians and Surgeons of London, granted a Royal Charter of Incorporation to their Society, neither he nor they had any idea that by 1974 that Society would welcome a group called the Open Section. For 4 years lay people had a place in the Library and Lay Section, but we sprang fully formed into the world as the Open Section after Oncology (1970) and before Medical and Dental Hypnosis, now Hypnosis & Psychosomatic Medicine (1977).

The Section's Regulations define our object as being a channel of communication between the medical profession and persons in other walks of life on matters within their mutual concern. Our current membership reflects the mixture necessary for maintaining such a channel. We have over 400 members, of whom 65 are medical doctors and 132 hold other degrees.

Our programmes have a variety unique within the Society. In the year before the NHS Review was published, we had conducted our own review of the NHS, with the title '40 Years On'. Our speakers ranged from Mr Enoch Powell, on the early days, to Sir Raymond Hoffenburg, on current professional choices and dilemmas. The report of our final day symposium was printed in *JRSM* and widely acclaimed.

Last year we considered what could be learned from the way other countries organized medical care from birth to old age. Our 1989-90 programme at every meeting considered an issue currently being examined in Parliament or in the Media: the Health Service and Community Care Bill, the supply of clean water, the Broadcasting Bill and research ethics committees. Having to plan our meetings so far ahead means that this linkage is problematic but, when it does happen that our discussions coincide with a high level of public awareness of the issues, this immediacy gives a particular vigour to the interchange of ideas.

I still find that other Sections are puzzled by the name of our Section and, in my very enjoyable time as President, I have often had to answer the question, 'What do you mean by *Open*?' I have thought of referring to open diplomacy, open letter, perhaps 'Open Sesame'; but I have now decided that the reference is to our *minds*. We welcome discussion of developments in science and medicine, and reflect upon the changes in our society and in patterns of health care. We welcome, therefore, approaches from other Sections who want to plan joint sessions and some of our most interesting discussions have come from meetings with other Sections.

I am delighted to hand over to our next President, Dr Zarrina Kurtz, paediatric epidemiologist at the Institute of Child Health. Dr Kurtz has made an excellent contribution as a member of Council and I am sure that her lively intelligence and commitment to public health promise an exciting programme.

For our framework for next year, our new President has chosen the seven ages of man, as defined by Jaques in *As You Like It*, and we will welcome all Fellows of the Society who wish to join us on our journey from first to second childishness, with our usual supply of 'wise saws and modern instances'.

Jean Lovell-Davis
Immediate Past President
Open Section

0141-0768/90/
080481-01/$02.00/0

Myalgic encephalomyelitis: an alternative theory

In his discussion paper on myalgic encephalomyelitis (April 1989 *JRSM*, p 215), Wessley drew attention to the destruction of body and mind, and subsequent suicidal despair, and torment, of patients suffering from myalgic encephalomyelitis (ME) or the postviral fatigue syndrome (PVFS). He referred to the reported relationship between identification of the VPI antigen and the presence of disease symptoms. He stated that more attention requires to be paid to methodological detail which he defined as population sample definition, and adoption of operational criteria. He suggested that a new term should be used to describe the observed symptoms: chronic fatigue syndrome (CFS), and enquired what constitutes the syndrome? Unfortunately he did not refer to the necessity for taking a complete clinical and family history in all patients. In his definition of CFS, he did not refer to any of the somatic symptoms which are always present. Yet, he stated that cases of this disease can only be selected by the (presumably holistic) clinical history. It appears that a new kind of approach based on absence of prejudice, more exhaustive and thorough clinical history taking, a wider approach to clinical examination of the patients, and a critical assessment of the origin of this psychosomatic disease would be of value in our investigations.

It should be remembered that CFS was first diagnosed in 1662 and referred to as the Vapours. Subsequently neurasthenia was described as an

0141-0768/90/
080481-03/$02.00/0

atonic condition of the nervous system with marked mental and physical fatiguability, in 1884. In 1970, the term total allergy syndrome came into popular use. This referred to patients having a variety of somatic and mental symptoms, fatigue, exhaustion, and psychiatric complaints, associated with food and chemical challenges[1]. Wessley implied that a good definition of *modern* neurasthenia, or ME, is required together with a coherent theory about its development and progress. It must be assumed that he is seeking an adequate explanation of why the psychosomatic integrity of the patient is damaged at the time when the disease is diagnosed, and the wide range of symptoms, and abnormal laboratory tests, are recognized.

Three of the most important clinical diagnostic signs in ME patients are: the allergic family history which is invariably present, the seasonal and circadian rhythms of the somatic, and mental, symptoms in the patients, and the fact that central nervous and psychiatric symptoms tend to persist after the somatic symptoms have begun to diminish. These comprise multiple symptoms, including hallucinations, noises and cotton-wool feelings which may move round in the head, headaches, tiredness, muscle weakness, fatigue, exhaustion, anxiety, and depression. As has been reported to occur in ME (November 1989 *JRSM*, p 693), so in migraine and other central nervous diseases of allergic origin, evidence of biochemical and neurological changes have been reported in the brain[2]. These symptoms are resistant to tranquiliser and antidepressant therapy in ME and chronic allergic disease. Indeed, the patients are often allergically sensitive to these drugs.

These symptoms are also characteristic of severe allergic disease. The allergic sensitivities can be diagnosed from the answers provided by the patients to an Allergy Questionnaire. Food sensitivities can be identified by likes, dislikes, and addictions to foods, and correlation with symptoms produced by their consumption[3]. Environmental allergic challenges to pollens, moulds, house dust, and chemicals, are identified by seasonal, circadian, and daily living and activity investigations. These sensitivities are confirmed by quick and simple non-invasive clinical allergy tests[4]. The allergic symptoms which the patients exhibit, reflect those recorded in the family history in about 100% patients[5,6].

Evidence of viral infection is claimed to be necessary for the diagnosis of ME. Many patients with chronic allergic disease have identical symptoms to ME patients. It is recognized that viral infections commonly have occurred in allergic patients suffering from previous, positive antigen-antibody reactions. This has now been demonstrated in patients with HIV infection[7]. The time when the viral infection occurred can be identified from the patient's clinical history. This infection may have occurred at any time after the allergic disease commenced. The identification of viral antibodies in the tissues confirms the existence of a previous viral challenge, as does clinical allergy testing. The viral challenge potentiates the allergic challenges and symptoms. It predominantly affects the central nervous system. It is therefore not surprising that the allergic central nervous challenges (such as those produced by water contaminants and chemicals[8]), increase the virally induced psychiatric and central nervous symptoms.

Recent American research[9] has shown that a psychopathological central challenge, defined as Alternative Multiple Personality (AMP), appears in patients with persistent allergic disease. Individual AMPs produce separate and specific allergic responses and symptom complexes whenever they become dominant. The original patient personality is completely unaware that this is taking place, until it is demonstrated by challenging the AMPs separately from the patient personality. In these circumstances the original psychosomatic patient may be non-allergic. These psychopathological patients learn to reproduce allergic symptoms in the absence of any allergic antigen-antibody challenge.

This psychopathological mechanism often appears as a consequence of stress, even the stress associated with the viral infection. We have been able to confirm this[10,11]. We have demonstrated that different, but specific, psychopathological mechanisms are responsible for producing particular imposed, learned responses independent of the patient's own personality. These resemble the original allergic reactions. Particular symptoms associated with these psychopathological mechanisms appear in the patients who have been diagnosed as suffering from ME and allergic disease. They continue to exhibit symptoms during dominance of the psychopathological central challenge, although they may still respond separately and to a limited extent, through the allergic mechanism to actual, specific, environmental, food, or viral, challenges[12].

Initial treatment for chronic allergic or ME patients is carried out by exclusion of dietary, chemical, or environmental challenges. This form of treatment is rarely advised in patients suffering from ME. Desensitization is relatively simple for dietary, environmental or other challenges which are socially unacceptable or persistent. These measures produce 50-75% relief of the immunologically produced symptoms, and confirm the allergic basis of the disease. The psychopathological central challenges are controlled by direct counselling, hypnotherapy, or most easily by a modification of the procedure used for desensitizing patients to their original allergic challenges[13-16].

Both the allergic, and psychopathological, symptoms can be relieved in patients diagnosed as suffering from ME associated with virus challenge, and demonstrated to have a previous history of allergic disease. This indicates that immunological challenge in sensitized patients, and a psychopathological imposed challenge through AMPs, and other central challenges, to the patient's personality, are responsible for initiation, and persistence, of ME symptoms. The effects of these successive and combined mechanisms are responsible for the damage to the psychosomatic integrity of chronic allergic patients, of ME and PVFS patients, and of the patients described in Wessley's discussion.

C W M Wilson
Murrayfield Hospital, Edinburgh, Scotland

References

1 Mackarness R. *Chemical victims*. London: Pan Books, 1988
2 Wilson CWM, Kirker JG, Warnes H, *et al.* The clinical features of migraine as a manifestation of allergic disease. *Postgrad Med J* 1979;13:18-20

3 Wilson CWM. Food sensitivities, taste changes, aphthous ulcers, and atopic symptoms, in allergic disease. *Ann Allergy* 1980;**44**:302-30
4 Wilson CWM. The neurophysiological implications of allergenic clinical titration in the treatment of allergic disease. *Med Hypotheses* 1986;**21**:71-85
5 Wilson CWM. Myalgic encephalomyelitis and/or allergic disease? *Action Against Allergy Newsletter* 1989;No.37:8-10
6 Rowe AH, Rowe A. *Food allergy. Its manifestations and control and the elimination diets.* Illinois: Charles C Thomas, 1972:19-20
7 Watson JM, Gill ON. HIV infection and tuberculosis. *Br Med J* 1990;**300**:63-5
8 Wilson CWM. The Raynaud phenomenon: its relationship to water contaminant allergic challenge. *Alternative Med* 1989;**3**:29-44
9 Braun B. Psychophysiologic phenomena in multiple personality and hypnosis. *Am J Clin Hypn* 1983;**26**:124-37
10 Wilson CWM. The association between allergic disease, entities, multiple personalities, and medical dowsing. *Alternative Med* 1987;**2**:215-28
11 Wilson CWM. A patient with AIE possession and multiple personality manifestation. *Sci Med Network Newsletter* 1989;No.41:10
12 Wilson CWM, Perry M. Deliverance and dowsing. *Christian Parapsychologist* 1990;**8**:195-7
13 Perry M. Current theological perspectives on possession. *Christian Parapsychologist* 1990;**8**:171-9
14 Wilson CWM. Have you a passenger in your car? or separability of the soul from the body. Parts 1 and 2. *New Humanity* 1989;No.89:5-8. No.90: 19-22
15 Maureg E. *Exorcism.* Pennsylvania: Whitford Press, 1988
16 Wilson CWM. Review of Exorcism (Maureg). *Christian Parapsychologist* 1990;**8**:(in press)

Wind of change-IV. Teaching hospitals in London 1938-1988

My experience of teaching hospitals is restricted to London. In 1938 there were thirteen of these voluntary hospitals concerned with the clinical teaching of undergraduates at the bedside or in the outpatient clinic. In my hospital, St Bartholomew's, we were also expected to attend some formal systematic and clinical lectures, a register being kept, but they were not popular. Our teachers were honorary physicians, surgeons and obstetricians (the 'Honoraries') who gave time and skill to the patients without any remuneration, but a small fee was paid by the medical college (University) for the lectures - about £100 per annum. Their real income came from private practice, which depended on contacts made with the general practitioners of the hospital patients, the GPs usually being alumni of the medical college. Understandably, the patients came from far and wide, for there was none of the imposition of catchment areas that has in recent years stifled clinical freedom in the National Health Service. The charges made to the patients were very small and were set aside in cases of hardship; for example, the amount requested of a new outpatient who could afford it was half-a-crown (2/6 or 12½ p - say £3 or $5 today).

The honoraries set an example of courtesy and charm when dealing with their patients, and only occasionally would one be brusque or boisterous. Some insisted on students remaining standing throughout the teaching rounds in the wards from 14.00 to 16.30 h, which had a soporific effect on warm summer afternoons. When students in their final year attended as well, the crowd round the bed was such that some of us could hardly see the patient, let alone the condition. On some days we had to wait around for the great chief to arrive in his Rolls, Studebaker or Packard straight from some intriguing case, the details of which he would recount as we followed expectantly behind him in a long tail, the length of which being an indication of the worth of the teacher. Such adulation would rarely be seen today, and such idols, even those with feet of clay, have largely disappeared. The scene now is more matey; the consultant being on first name terms with the students; even dressed similarly (possibly wearing a two-piece suit but almost certainly not braces and waistcoat)!

At that time some of the hospitals had sprouted small medical and surgical units staffed by full-time university professors and assistant directors, mostly conscientious and good. Also, we appreciated the fact that all those who taught us the basic medical sciences of anatomy, physiology and biochemistry were medically qualified and had clinical experience; this has not commonly been the case in recent years and students are concerned about it. Also today a tendency has developed for students to become 'turned off' from their original call to medicine because of the delay in getting 'hands on' experience. This is caused by the welter of basic medical science that does not seem to relate to the job they want to get to grips with, and to which they have to return when preparing for a postgraduate specialty. In my day there were some experimental physiology and biochemistry practicals which we disliked, but few of us ever seemed to be 'turned off', even the odd types, the chronic students, who made a snail's pace through the college without fear of dismissal (unlike today) and they, when the war came, either joined the forces immediately or like the rest got on with the slightly shortened course and qualified MRCS LRCP, the MB being taken 6 months later at the end of the house job and before National Service, or being delayed until after the war.

The wind of change caused by the Second World War blew strongly on the teaching hospitals. Each became the apex of an Emergency Medical Service (EMS) sector, extending for up to 50 miles around and embracing local hospitals, sanatoria and asylums, all suitably modified and extended with hutted wards to accommodate the London patients who were bussed out twice a week to lie alongside the sick and wounded from the forces and those injured in the Battle of London (the Blitz). Clinical teaching was also, but not totally evacuated, and the students, who in the course of time were to become the consultants and professors in the vintage years of the National Health Service (1948-1973), were enlightened when they found that very good 'hands on' clinical experience could actually be obtained outside London, even north of Watford Junction, south of Dulwich, east of Whitechapel and

0141-0768/90/
080483-03/$02.00/0